		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025460

Facility Name: FOREST VILLA

Address: 6840 W. TOUHY AVENUE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: (847) 647-8994 **Fax #** (847) 647-0500

IDPA ID Number: 36-3077541

Date of Initial License for Current Owners: 07/01/80

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 11/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROBERT KAPLAN
(Title) COMPTROLLER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	19,038	1
2		Skilled Pediatric (SNF/PED)			2
3	155	Intermediate (ICF)	155	51,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	212	TOTALS	212	70,808	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,800	1,227	3,213	9,240	8
9	SNF/PED					9
10	ICF	35,200	8,213		43,413	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,000	9,440	3,213	52,653	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.36%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/80

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 2,534

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	285,003	29,331	33,975	348,309		348,309	0	348,309			1
2	Food Purchase		276,263		276,263	(60,006)	216,257	0	216,257			2
3	Housekeeping	219,211	33,668	15,250	268,129		268,129	0	268,129			3
4	Laundry	83,405	26,944	5,750	116,099		116,099	0	116,099			4
5	Heat and Other Utilities			136,467	136,467		136,467	0	136,467			5
6	Maintenance	92,761		67,556	160,317		160,317	(1,328)	158,989			6
7	Other (specify):*			25,915	25,915		25,915	0	25,915			7
8	TOTAL General Services	680,380	366,206	284,913	1,331,499	(60,006)	1,271,493	(1,328)	1,270,165			8
	B. Health Care and Programs											
9	Medical Director	0		5,600	5,600		5,600	0	5,600			9
10	Nursing and Medical Records	2,259,999	133,941	168,958	2,562,898		2,562,898	0	2,562,898			10
10a	Therapy	210,088		27,551	237,639		237,639	0	237,639			10a
11	Activities	121,378	5,294	8,500	135,172		135,172	0	135,172			11
12	Social Services	193,818		15,528	209,346		209,346	0	209,346			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):* accrued vacation				0		0	0	0			15
16	TOTAL Health Care and Programs	2,785,283	139,235	226,137	3,150,655	0	3,150,655	0	3,150,655			16
	C. General Administration											
17	Administrative			405,000	405,000		405,000	(352,111)	52,889			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			138,239	138,239		138,239	(57,956)	80,283			19
20	Dues, Fees, Subscriptions & Promotions			64,393	64,393		64,393	(29,537)	34,856			20
21	Clerical & General Office Expenses	110,637	61,544	93,090	265,271		265,271	112,398	377,669			21
22	Employee Benefits & Payroll Taxes			466,193	466,193	60,006	526,199	(78,448)	447,751			22
23	Inservice Training & Education			4,381	4,381		4,381	0	4,381			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			6,779	6,779		6,779	0	6,779			25
26	Insurance-Prop.Liab.Malpractice			197,209	197,209		197,209	(38,446)	158,763			26
27	Other (specify):* accrued vacation				0		0	24,548	24,548			27
28	TOTAL General Administration	110,637	61,544	1,375,284	1,547,465	60,006	1,607,471	(419,552)	1,187,919			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,576,300	566,985	1,886,334	6,029,619	0	6,029,619	(420,880)	5,608,739			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FOREST VILLA #0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			113,666	113,666		113,666	54,025	167,691			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			50,392	50,392		50,392	25,288	75,680			32
33	Real Estate Taxes			204,109	204,109		204,109	0	204,109			33
34	Rent-Facility & Grounds			603,948	603,948		603,948	(603,948)	0			34
35	Rent-Equipment & Vehicles			49,957	49,957		49,957	(24,336)	25,621			35
36	Other (specify):*			167	167		167	0	167			36
37	TOTAL Ownership			1,022,239	1,022,239	0	1,022,239	(548,971)	473,268			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		41,491	84,815	126,306		126,306	0	126,306			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			106,212	106,212		106,212	0	106,212			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	41,491	191,027	232,518	0	232,518	0	232,518			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,576,300	608,476	3,099,600	7,284,376	0	7,284,376	(969,851)	6,314,525			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,842)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(16,062)	21		18
19	Entertainment	0	20		19
20	Contributions	(750)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(62,105)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(28,787)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	(180,167)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (302,713)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(667,138)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (667,138)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (969,851)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FOREST VILLA

ID# 0025460

Report Period Beginning: 01/01/2001

Ending: 11/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -1328	6	1
2				2
3	WORKMANS' COMP	(78,448)	22	3
4	PROPERTY INSURANCE	(38,446)	26	4
5	AUTO LEASE	(27,409)	35	5
6	TELEPHONE	(9,868)	21	6
7	BANK CHARGES	(24,668)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(180,167)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number FOREST VILLA **#** 0025460 **Report Period Beginning:** 01/01/2001 **Ending:** 11/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,328)	0	0	0	0	0	0	0	0	0	0	(1,328)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,328)	0	0	0	0	0	0	0	0	0	0	(1,328)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(352,111)	0	0	0	0	0	0	0	0	0	(352,111)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(62,105)	4,149	0	0	0	0	0	0	0	0	0	(57,956)	19
20	Fees, Subscriptions & Promotions	(29,537)	0	0	0	0	0	0	0	0	0	0	(29,537)	20
21	Clerical & General Office Expenses	(50,598)	162,996	0	0	0	0	0	0	0	0	0	112,398	21
22	Employee Benefits & Payroll Taxes	(78,448)	0	0	0	0	0	0	0	0	0	0	(78,448)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(38,446)	0	0	0	0	0	0	0	0	0	0	(38,446)	26
27	Other (specify):*	0	24,548	0	0	0	0	0	0	0	0	0	24,548	27
28	**TOTAL General Administration**	(259,134)	(160,418)	0	0	0	0	0	0	0	0	0	(419,552)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(260,462)	(160,418)	0	0	0	0	0	0	0	0	0	(420,880)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number FOREST VILLA **#** 0025460 **Report Period Beginning:** 01/01/2001 **Ending:** 11/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(14,842)	2,552	66,315	0	0	0	0	0	0	0	0	54,025	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	25,288	0	0	0	0	0	0	0	0	25,288	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(603,948)	0	0	0	0	0	0	0	0	(603,948)	34
35	Rent-Equipment & Vehicles	(27,409)	3,073	0	0	0	0	0	0	0	0	0	(24,336)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(42,251)	5,625	(512,345)	0	0	0	0	0	0	0	0	(548,971)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(302,713)	(154,793)	(512,345)	0	0	0	0	0	0	0	0	(969,851)	45

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARNOLD KAPLAN	58	KANKAKAEE NURSING & REHAB	KANKAKEE	FAMILY CARE	NILES	MANAGEMENT
MICHAEL KAPLAN	14	MORTON TERRACE	MORTON	MANAGEMENT		
ELISE KAPLAN	9	MORTON VILLA	MORTON			
ROBERT KAPLAN	13			6840 PARTNERSHIP	NILES	LANDLORD
DEANNA KAPLAN	6					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 405,000	FAMILY CARE MANAGEMENT	100.00%	$	$ (405,000)	1
2	V	17	ADMINISTRATIVE				52,889	52,889	2
3	V	19	PROFESSIONAL FEES				4,149	4,149	3
4	V	21	CLERICAL				162,996	162,996	4
5	V	27	EMPLOYEE BEN. & TAXES				24,548	24,548	5
6	V	30	DEPRECIATION				2,552	2,552	6
7	V	35	OFFICE RENT				3,073	3,073	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 405,000			$ 250,207	$ * (154,793)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 603,948	6840 PARTNERSHIP	100.00%	$	$ (603,948)	15
16	V	30	DEPRECIATION				66,315	66,315	16
17	V	32	INTEREST				25,288	25,288	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 603,948			$ 91,603	$ * (512,345)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL KAPLAN	ADMIN.	Administration	0.14	77,111	see attached		administrative	$ 52,889	17-3	1
2	ROBERT KAPLAN	BOOKKEEPER	Bookkeeping	0.13	77,111	see attached		bookkeeping	52,889	21-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 105,778		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Family Care Management
Street Address: 6840 W Touhy
City / State / Zip Code: niles,il
Phone Number: (847)647-8994
Fax Number: (847)647-0500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	RESIDENT DAYS	129,419	4	$ 130,000	$ 130,000	52,653	$ 52,889	1
2	19	PROFESSIONAL FEES	RESIDENT DAYS	129,419	4	10,199		52,653	4,149	2
3	21	CLERICAL	RESIDENT DAYS	129,419	4	400,637	399,417	52,653	162,996	3
4	27	EMPLOYEE BEN. & TAXES	RESIDENT DAYS	129,419	4	60,339		52,653	24,548	4
5	30	DEPRECIATION	RESIDENT DAYS	129,419	4	6,273		52,653	2,552	5
6	35	OFFICE RENT	RESIDENT DAYS	129,419	4	7,554		52,653	3,073	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 615,002	$ 529,417		$ 250,207	25

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: 6840 PARTNERSHIP
Street Address: 6840 W. TOUHY
City / State / Zip Code: NILES,IL 60648
Phone Number: (847)498-1116
Fax Number: (847)498-1011

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 66,315	$	1	$ 66,315	1
2	32	INTEREST	DIRECT	1	1	25,288		1	25,288	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 91,603	$		$ 91,603	25

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	RELATED PARTY											2
3	6840 PRTNERSHIP			MORTGAGE	$25,035.00	9/1/93	2,350,000	146,553	1/02	0.0850	25,288	3
4												4
5												5
	Working Capital											
6	LASALLE NATIONAL BANK		X	LINE OF CREDIT	INTEREST						50,392	6
7												7
8												8
9	TOTAL Facility Related				$25,035.00		$ 2,350,000	$ 146,553			$ 75,680	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 2,350,000	$ 146,553			$ 75,680	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 215,450	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 217,559	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,109	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 202,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 204,109	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	198,698	8
	1997	204,880	9
	1998	210,477	10
	1999	213,317	11
	2000	217,559	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOREST VILLA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0025460

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-30-317-044-0000	NURSING HOME	$ 125,551.29	$ 125,551.29
2.	10-30-317-030-0000	NURSING HOME	$ 92,008.20	$ 92,008.20
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 217,559.49	$ 217,559.49

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,000 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	114,267	1982	$ 132,061	1
2					2
3	TOTALS	114,267		$ 132,061	3

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5	206		1982		2,514,661	65,860	35	65,860		1,371,081	5
6			1983		17,370	455	35	455		9,797	6
7											7
8											8
	Improvement Type**										
9	SPRINKLE SYSTEM			1982	50,599		25			50,599	9
10	ELECTRIC			1983	5,625		10			5,625	10
11	IMPROVEMENT			1986	6,155	320	15	210	(110)	6,155	11
12	IMPROVEMENT			1986	90,650	4,714	25	3,626	(1,088)	56,203	12
13	IMPROVEMENT			1987	17,807	565	20	890	325	12,905	13
14	IMPROVEMENT			1988	19,400	1,147	15	1,145	(2)	16,564	14
15	IMPROVEMENT			1989	71,120	2,257	31.5	2,257		27,962	15
16	IMPROVEMENT			1990	29,270	929	31.5	929		10,623	16
17	IMPROVEMENT			1991	24,339	773	31.5	773		8,213	17
18	IMPROVEMENT			1992	8,400	267	31.5	267		2,604	18
19	IMPROVEMENT			1993	10,990	348	31.5	348		3,067	19
20	A/C HEATING CENTRAL UNIT			1994	5,100	131	39	131		1,007	20
21	FLOOR REPAIR			1994	2,195	56	39	56		413	21
22	WATER HEATER & PLUMBING			1995	3,640	93	39	93		609	22
23	ELEVATOR			1995	37,320	957	39	957		6,020	23
24	ELECTRICAL			1995	1,152	30	39	30		193	24
25	WATER HEATER & PLUMBING			1995	9,645	247	39	247		1,565	25
26	NEW DINING ROOM			1996	719,683	18,453	39	18,453		109,976	26
27	PATCH ROOF			1996	6,750	173	39	173		1,017	27
28	CUSTOM BUILT NURSE STATION			1996	6,914	177	39	177		1,040	28
29	SIGN			1996	748	19	39	19		107	29
30	CONSTRUCTION OF NEW WALLS			1996	10,780	276	39	276		1,553	30
31	FIRE DOORS			1996	7,630	196	39	196		1,102	31
32	SPRINKLE SYSTEM			1996	2,991	77	39	77		433	32
33	INSULATION WORK			1996	1,000	26	39	26		142	33
34	SHOWER ROOM REMODELING			1996	1,283	33	39	33		172	34
35	DIALYSIS STATION			1997	6,800	174	39	174		790	35
36	FIRE DOORS			1997	24,318	624	39	624		2,833	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ROOM REHAB	1997	$ 13,557	$ 347	39	$ 347	$	$ 1,576	37
38	THERAPHY ROOM REHAB	1997	22,346	573	39	573		2,602	38
39	ROOF TOP HEATER/AIR CONDITIONER	1997	11,500	295	39	295		1,340	39
40	ELECTRICAL WORK	1997	783	20	39	20		91	40
41	CUSTOM NURSE STATION	1997	10,976	281	39	281		1,276	41
42	BUILT-IN CABINETS THERAPHY ROOM	1997	7,018	180	39	180		817	42
43	COOLING TOWER	1997	12,920	331	39	331		1,503	43
44	WINDOWS	1997	41,620	1,067	39	1,067		4,846	44
45	ROOF FACIA	1997	9,045	232	39	232		1,054	45
46	ALARM SYSTEM	1997	33,051	849	39	849		3,855	46
47	BATHROOM REMODELING	1998	145,938	3,741	39	3,741		14,497	47
48	ELECTRICAL WORK	1998	3,648	93	39	93		361	48
49	CORNER GUARDS	1998	417	11	39	11		42	49
50	DOOR	1998	1,770	45	39	45		163	50
51	KITCHEN SINK AND GREASE TRAP	1998	3,806	98	39	98		355	51
52	PHOTO ELECTRIC SMOKE DETECTORS	1998	3,080	79	39	79		286	52
53	PLUMBING WORK	1998	3,031	78	39	78		263	53
54	GARDEN WINDOW	1998	2,290	59	39	59		199	54
55	WINDSTORM WINDOWS	1998	55,950	1,435	39	1,435		4,484	55
56	BOILER	1999	2,414	62	39	62		158	56
57	ROOF REPAIR	1999	8,000	205	39	205		521	57
58	SINKS & FAUCETS	1999	675	17	39	17		43	58
59	TILING	1999	14,313	367	39	367		933	59
60	DOOR	1999	2,260	58	39	58		147	60
61	TOILETS	1999	3,919	100	39	100		254	61
62	FIRE DOORS	1999	3,490	89	39	89		226	62
63	CUSTOM CABINETS	1999	10,672	274	39	274		696	63
64	DIALYSIS ROOM	1999	22,100	567	39	567		1,441	64
65	BOILER TUBE	1999	3,842	99	39	99		251	65
66	AWNINGS	1999	3,649	94	39	94		239	66
67	NURSE STATION	1999	5,985	153	39	153		389	67
68	VALVES, PUMPS	1999	6,243	160	39	160		407	68
69	CUSTOM CABINETS	1999	4,168	107	39	107		272	69
70	TOTAL (lines 4 thru 69)		$ 4,188,811	$ 111,543		$ 110,668	$ (875)	$ 1,755,957	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,188,811	$ 111,543		$ 110,668	$ (875)	$ 1,755,957	1
2	HOT WATER HEATER	1999	2,418	62	39	62		158	2
3	VENT	2000	2,945	107	27.5	107		165	3
4	DOOR	2000	1,780	65	27.5	65		100	4
5	AIRHANDLER COILS	2000	10,362	377	27.5	377		581	5
6	WATER HEATER	2000	18,703	680	27.5	680		1,049	6
7	WATER PUMP	2000	4,753	173	27.5	173		267	7
8	ELECTRICAL WORK	2000	6,216	226	27.5	226		348	8
9	ELECTRICAL WORK	2000	2,698	98	27.5	98		151	9
10	CORNICE	2000	2,195	538	7	538		852	10
11	DRAPES	2000	5,159	1,263	7	1,263		2,000	11
12	WALLCOVERINGS	2000	1,511	370	7	370		586	12
13	CARPET	2000	2,068	506	7	506		802	13
14	LEASEHOLD IMPROVEMENTS	2001	53,312	970	27.5	970		970	14
15	FURNISHINGS	2001	6,944	1,389	5	1,389		1,389	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,309,875	$ 118,367		$ 117,492	$ (875)	$ 1,765,375	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 826,601	$ 59,105	$ 47,020	$ (12,085)	10 YRS	$ 397,012	71
72	Current Year Purchases	12,545	2,509	627	(1,882)	10 YRS	627	72
73	Fully Depreciated Assets	525,767			0	5-10 YRS	525,767	73
74	related party-kaf		2,552	2,552	0			74
75	TOTALS	$ 1,364,913	$ 64,166	$ 50,199	$ (13,967)		$ 923,406	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,806,849	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 182,533	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,691	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (14,842)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,688,781	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 8,648 Description: copy machine$8423,postage machine$225
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE		$ 670.00	$ 6,700	17
18			720.00	7,200	18
19	NON ALLOW AUTO			27,409	19
20					20
21	TOTAL		$ 1,390.00	$ 41,309	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 11,010	$		$ 11,010	1
2	Licensed Speech and Language Development Therapist		hrs			13,693			13,693	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			60,112			60,112	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				18,844		18,844	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies						22,647		22,647	13
14	TOTAL			$		$ 84,815	$ 41,491		$ 126,306	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number FOREST VILLA # 0025460 **Report Period Beginning:** 01/01/2001 **Ending:** 11/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 64,013	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	927,694		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 991,707	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,759,967		15
16	Equipment, at Historical Cost	1,258,660		16
17	Accumulated Depreciation (book methods)	(1,531,980)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): OPTION DEPOSIT	(1,000,000)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 486,647	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,478,354	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 77,910	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	202,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO TENANTS	40,313		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 320,223	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 320,223	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,158,131	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,478,354	$ 0	48

***(See instructions.)**

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,790,315	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,790,315	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(172,839)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(459,345)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (632,184)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,158,131	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,785,715	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,785,715	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	171,086	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 171,086	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	(6,921)	28
28a	Rental Income	161,657	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 154,736	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,111,537	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,331,499	31
32	Health Care	3,150,655	32
33	General Administration	1,547,465	33
	B. Capital Expense		
34	Ownership	1,022,239	34
	C. Ancillary Expense		
35	Special Cost Centers	126,306	35
36	Provider Participation Fee	106,212	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,284,376	40
41	**Income before Income Taxes (line 30 minus line 40)****	(172,839)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (172,839)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,840	1,902	$ 65,008	$ 34.18	1
2	Assistant Director of Nursing	5,087	5,602	123,971	22.13	2
3	Registered Nurses	28,435	30,775	672,105	21.84	3
4	Licensed Practical Nurses	10,666	11,725	237,086	20.22	4
5	Nurse Aides & Orderlies	94,442	98,772	1,131,048	11.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	18,772	20,945	210,088	10.03	8
9	Activity Director	1,520	1,817	28,499	15.68	9
10	Activity Assistants	9,412	9,648	92,879	9.63	10
11	Social Service Workers	12,861	13,824	193,818	14.02	11
12	Dietician					12
13	Food Service Supervisor	1,763	1,977	42,134	21.31	13
14	Head Cook	6,006	6,575	67,770	10.31	14
15	Cook Helpers/Assistants	21,452	22,972	175,099	7.62	15
16	Dishwashers					16
17	Maintenance Workers	4,981	5,620	92,761	16.51	17
18	Housekeepers	25,105	27,123	219,211	8.08	18
19	Laundry	9,985	10,784	83,405	7.73	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,575	9,642	110,637	11.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,841	3,382	30,781	9.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,743	283,085	$ 3,576,300 *	$ 12.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 10,470	1-3	35
36	Medical Director	O	5,600	9-3	36
37	Medical Records Consultant	N	5,106	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	11,626	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47		S			47
48					48
49	TOTAL (lines 35 - 48)		$ 32,802		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
	ADMIN		$ 0
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
FAMILY CARE MANAGEMENT LTD-MANAGEMENT FEE	$ 405,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 405,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED		138,239
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 138,239

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,357
Unemployment Compensation Insurance	18,270
FICA Taxes	273,896
Employee Health Insurance	55,768
Employee Meals	60,006
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS-OTHER	5,174
EMPLOYEE PHYSICAL EXAMS	1,280
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,751

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,040
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	28,787
TRUST FEES/FRANCHISE TX/ETC	0
CONTRIBUTIONS	750
DUES & SUBSCRIPTIONS	12,180
LICENSES & PERMITS	3,636
TRUST FEES/FRANCHISE TX/ETC	0
Less: Public Relations Expense	(750)
Non-allowable advertising	(28,787)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,856

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 0

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	6/00	$ 3,906	3 YRS	$	$	$ 651	$ 1,302	$ 1,302	$ 651	$	$	$
2	PAINT/DECORATING	6/01	3,156	3 YRS				526	1,052	1,052	526		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,062		$	$	$ 651	$ 1,828	$ 2,354	$ 1,703	$ 526	$	$

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2001 Ending: 11/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC $10590**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,461** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **106,212**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **60,006** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: FOREST VILLA **#0025460** **Report Period Beginning: 01/01/2001** **Ending: 11/30/01**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,470	
	REPAIRS & MAINTENANCE		3,755	
	ACCRUED VACATION PAY		19,750	33,975
3	**HOUSEKEEPING**			
	ACCRUED VACATION PAY		15,250	
			0	15,250
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	ACCRUED VACATION PAY		5,750	5,750
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		55,835	
	ELECTRICITY		55,415	
	WATER		18,644	
	CABLE TV - LOBBY		6,573	
			0	136,467
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,741	
	PAINTING & DECORATING		3,156	
	BUILDING REPAIRS		16,503	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		2,200	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,657	
	FIRE SERVICE		372	
	BUILDING MAINTENANCE & SUPPLIES		26,861	
	DEFERRED PAINT & DECORATING		1,566	
	ACCRUED VACATION PAY		6,500	67,556
7	**OTHER**			
	SCAVENGER		25,915	
	SECURITY SERVICE		0	25,915
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,600	5,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	4,038	
	LABORATORY & XRAY EXPENSE		1,814	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	5,106	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	ACCRUED VACATION PAY		158,000	
			0	168,958
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		1,175	
	SPEECH THERAPY SERVICES		0	
	ACCRUED VACATION PAY		14,750	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	11,626	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	27,551
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	ACCRUED VACATION PAY		8,500	8,500
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		2,028	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
	ACCRUED VACATION PAY		13,500	15,528
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number FOREST VILLA **#0025460** **Report Period Beginning: 01/01/2001** **Ending: 11/30/01**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	405,000	405,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	20,905	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	117,334	
			0	138,239
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	28,787	
	EMPLOYEE WANT ADS	XIX F	19,040	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	12,180	
	LICENSES & PERMITS	XIX F	3,636	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	750	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	64,393
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		24,668	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	16,062	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		44,360	
	MESSENGER SERVICE		0	
	ACCRUED VACATION PAY		8,000	93,090

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	273,896	
	UNEMPLOYMENT COMPENSATION	XIX D	18,270	
	WORKERS COMPENSATION INSURANC	XIX D	111,805	
	HOSPITALIZATION INSURANCE	XIX D	55,768	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,174	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,280	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	466,193
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,381	4,381
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,779	6,779
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		197,209	197,209
27	**OTHER**			
	BAD DEBT	VI 24		
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,886,334

FOREST VILLA
EMPLOYEE MEAL RECLASSIFICATION
11/30/01

TOTAL FOOD PURCHASE	276,263
LESS SALES TAX	0
NET FOOD	276,263
TOTAL PATIENT CENSUS	52,653
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	157959
ADD # EMPLOYEE MEALS/DAY	120
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	43800

PATIENT MEALS	157959
ADD EMPLOYEE MEALS	43800
TOTAL MEALS/YEAR	201759
NET FOOD	276263
DIVIDE TOTAL MEALS/YEAR	201759
COST PER MEAL	1.37
TIME EMPLOYEE MEALS	43800
EMPLOYEE MEAL RECLASSIFICATION	60006